Chantilly Dental Center

3901 CENTERVIEW DRIVE, STE T. CHANTILLY, VA 20151
T: (703)-467-0214 F: (703)-467-0568 E: CHANTILLYDENTALCENTER@GMAIL.COM

Thank you for visiting Chantilly Dental Center. We want your visit to be pleasant and comfortable. Please help us by completing this form.

PATIENT INFORMATION DATE:

Name: _____
First Last Middle Initial Nickname

Address: _____
Street Apt/Unit #

_____
City State ZIP

Employer

Drivers License _____

Phone: Home: ( ) _____
Work:: ( ) _____
Mobile ( ) _____

Emergency Contact: _____

E-mail Address _____

Birth Date: _____

Social Security #_____

May we contact you at work? ☐ Yes ☑ No

☑ Male ☐ Female

Phone ( ) _____ Relationship: _____

INSURANCE

Primary Dental Carrier

Subscriber Name _____ SSN / ID# _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group #: _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ SSN / ID # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co.Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ Date _____

IF PATIENT IS UNDER 18

Responsible Party _____ Relation to Patient _____

Address: Street: Apt/Unit# City: State: Zip:

Telephone ( ) _____

OTHER INFORMATION

How did you hear about us? _____

What was the reason for today's visit?

MEDICAL HISTORY AND INFORMATION

Conditions

Y	N	
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina
☐	☐	Arthritis
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Blood Disorder
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Drug / Alcohol Abuse
☐	☐	Emphysema
☐	☐	Epilepsy / Fainting
☐	☐	Fever Blisters
☐	☐	Headaches / Migraine
☐	☐	Gastrointestinal Problem
☐	☐	Glaucoma
☐	☐	HIV
☐	☐	Heart Murmur
☐	☐	Heart Disease
☐	☐	Hepatitis A B C

Y	N	
☐	☐	Hormone Deficiency
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	immunosuppression
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Lung Disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Venereal Disease

Other:

Allergies

Y	N	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Iodine
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin

If Female

y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant?
		If yes, # of weeks _____
☐	☐	Are you nursing?

Please list any medications you are currently taking: _____

TREATMENT AUTHORIZATION FORM

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility.

PATIENT'S SIGNATURE: _____ Date: _____

PARENT'S/LEGAL GUARDIAN SIGNATURE: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

SIGNATURE: _____ Date: _____

OFFICE USE 0NLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date Initials Reason

Chantilly Dental Center

GENERAL DENTISTRY INFORMED CONSENT FORM

*Please note that you may not need to have any of these services performed.
By signing, you acknowledged that you have read and understood the risks if you should need to have the listed services performed.*

Patient's Name: _____

_____ 1. **EXAMINATION AND X-RAYS:** I understand that the initial visit will require radiographs in order to complete the examination, diagnosis, and treatment plan.

_____ 2. **DRUGS. MEDICATION, AND SEDATION:** I have been informed and understand that antibiotic, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock {severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand that and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic medication and drugs that may ave been given me in the office for my treatment. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection, pain, and potential resistance to effect treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

_____ 3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

_____ 4. **TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ):** I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower {near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, and the cost of which is my responsibility.

_____ 5. **FILLINGS:** I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage, and tooth sensitivity is common after-effect of a newly placed filling.

_____ 6. **REMOVAL OF TEETH (EXTRACTION):** Alternative to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment. I understand the risks involved is having teeth removed, some of which are pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue {parathesia) that can last for an indefinite period of time or fractured jaw. I understand I may

need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

_____7. **CROWNS, BRIDGES, VENEERS AND BONDING:** I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. Ifurther understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized that the final opportunity to make changes in my new crowns, bridge or cap (including shape, fit, size, placement, and color) will be done before cementation. It has been explained to me that, in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

_____8. **DENTURES – COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial, constructed of plastic, metal and or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not the initial denture fee.

_____9. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my tooth and those complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

___10. **PERIODONTAL TREATMENT:** t'understand that I have a serious condition causing gum inflammation and/or bone loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including non-surgical cleaning, gum surgery and/or extractions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receive regular cleaning as directed, following a healthy diet, avoid tobacco products and follow other recommendations.

CONSENT: *I understand that dentistry is not an exact science, therefore: reputable practitioner cannot properly guarantee results. I acknowledge that no guarantee or assurance as been made by anyone regarding the dental treatment which I have requested and authorize. I understand that each Dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Dentist other than the treating Dentist is responsible for my dental treatment.*

Patient's Signature: _____

Print Name : _____ **DATE:** _____

Chantilly Dental Center

FINANCIAL POLICY

The Chantilly Dental Center's mission is to provide the highest quality care in a comfortable and caring environment to each and every patient. We pride ourselves on our patient-centered practice, where we perform the highest level of care and service in a clean and well-organized environment.
All recommended treatments are in the best interest of our patients. We will not allow your dental insurance to dictate your treatment plan; therefore we will inform you before we perform any recommended treatment.

DENTAL INSURANCE

We accept assignment of estimated insurance benefits as a courtesy to our patients. You must inform us about your *primary* dental insurance. Please remember that your dental insurance is a contract between you and the insurance company. It is not a contract between the dentist and the insurance company. Our usual and customary fees, which are modest with our geographical area, are a reflection of our commitment to excellence. *All estimatect co-pays and deductibles are due at the time of service.*

All insurance claims are submitted within 24 hours. However, we have found that some insurance companies do not reimburse us within an adequate timeframe. After 30 days, we will re-submit the claim as an added courtesy to you. If the claim is still not paid 60 days after, due to any reason, you will be responsible for the total amount. We strongly recommend that you follow up with your insurance company to ensure prompt processing of claims.

Balances remaining after 90 days may accrue interest and may be sent to a collection agency.
Chantilly Dental Center will not accept secondary dental insurances. We recommend that you read your policy carefully to be fully aware of any restrictions that may apply to your dental benefits. For your convenience, we may process your secondary insurance claim for a small fee of fifteen dollars ($15) per claim.

Patients, who are enrolled in any HMO Dental Plan, please remember that your plan offers you a comprehensive treatment at a discount for our usual and customary fees. In accordance with your contract, all payments are due in full at the time of service, unless other arrangements have been made. In the event that your dental insurance does not cover your treatment or is canceled / terminated, or cannot be verified for any reason, the patient or the responsible party will be responsible for the entire fee amount including the insurance portion.

EMERGENCY PATIENTS

Please note that our policy requires verification of insurance. In the event that we are not able to verify your insurance information, payment will be due at the time of service. We will assist you in submitting a claim to your insurance company, so that the insurance company will reimburse you directly for your visit.

X-RAY AND RECORD DUPLICATION FEE

In the event that you should request a duplication of your x-rays, you are required to fill out a HIPM release form. There will be a fee of $15-$25, depends on the type of x-rays you request. Payment is due upon request of duplicating services. The process will take up from 5 to 10 business days.

APPOINTMENTS

Your appointment is a time especially reserved for you and for your dental care needs. We strive to give each patient a courtesy call one two days in advance of your scheduled dental visit. *However, you are expected to keep your appointment time with or without the courtesy call.* Therefore we ask your consideration that you kindly give 48-hour notice (for a general appointment, and at least one week for any Specialist appointment) if you are unable to keep your appointment, to avoid any cancellation fee. For broken appointments: there may be a $75.00 fee for a 30-60 minutes appointment, and $150.00 fee for a 60-or more minutes appointment is what you will be charged.

All treatment appointments where patient has a co-payment, our office requires an appointment reservation fee of $50-$100.00, depending upon patient co-payment. This fee reserves your appointment time. Upon completion of your appointment, this fee gets applied to your total co-payment. In the event that an inadequate notice is not given to cancel or reschedule the appointment, you will forfeit the appointment reservation fee. We understand that emergencies do arise; we will take this into consideration.

PREFERRED METHOD OF PAYMENT

For your convenience·, we accept Cash, I. ATM/Check cards and all Major Credit Cards - American Express, MasterCard, Visa, Discover, and Checks (with proper I.D.). We also use an automated telecheck service, which electronically withdraws the payment from your account or insures payment. There will be a fifty dollar ($50) returned check fee applied to your account in the bank denies your check for any reason. As an added courtesy, we also offer a revolving line of credit through a third party (upon credit approval). This line of credit allows you to start treatment today and spread payments over a comfortable period of time. Please feel free to ask our business coordinator if you are interested in this type of payment.

For treatment plans that exceed one thousand dollars ($1000.00); *we offer a prepaid discount of 5% when paid in full by cash, A TM/Check card and all Major Credit Cards before treatment begins.*

The parent or guardian that brings a minor in for treatment is the financially responsible party. Financial arrangements between individual parental parties do not absolve the parent bringing the minor from their financial obligation to our practice.

By signing below, I acknowledge that I have read, understood, and agreed to the provisions of the above policy.

Patient's Name: _____

PARENT/GUARDIAN NAME: _____

(IF PATIENT JS A MINC

SIGNATURE: _____ Date: _____

Send Form